

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN8601	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/14/2017
NAME OF PROVIDER OR SUPPLIER ERWIN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 100 STALLING LANE ERWIN, TN 37650		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments A Licensure Health survey and complaint investigation #41166 were conducted from 6/12/17 through 6/14/17 at Erwin Health Care Center. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000			

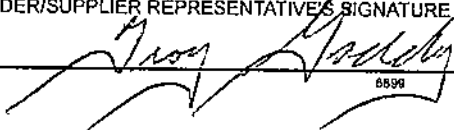
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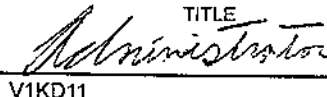
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM




Administrator

7/3/17

V1KD11

If continuation sheet 1 of 1